TMF
Health Quality Institute

Bridgepoint I, Suite 300
5918 West Courtyard Drive • Austin, TX 78730-5036
Phone 512-329-6610 • Fax 1-800-725-8293 • www.tmf.org

Notice of Independent Review Decision

DATE OF REVIEW: 08/20/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Arthrodesis, interphalangeal joint, with or without internal fixation

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The TMF physician reviewer is a board certified orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the arthrodesis, interphalangeal joint, with or without internal fixation is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
- Information for requesting a review by an IRO – 08/14/12
- Letter of determination from – 08/01/12, 08/06/12, 08/08/12
- Letter from Utilization Management – 08/14/12
- Review by – 07/31/12, 08/07/12
- Insurance claim form and second opinion by – 05/31/12
- Report of Functional Capacity Evaluation – 04/18/12
- Surgeries or Procedures To Be Scheduled Form – 07/11/12
- Preauthorization Request – 07/27/12
- General orthopaedic clinic notes by – 07/11/12
- Orthopedic Hand Clinic Notes by – 02/01/12 to 07/11/12
- Report of x-rays of the right finger – 02/01/12, 07/11/12
- Office Visit Notes by – 09/30/11 to 11/29/30
- Portion of emergency department record from – 09/24/11
- Report of x-rays of the right hand – 09/30/11, 10/21/11, 11/29/11

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on that resulted in a crushed right ring finger. He suffered a fracture of the tuft of the distal phalanx. The patient has been treated with surgery and physical therapy. The patient continues to have right finger pain at the DIP (distal interphalangeal) joint that is associated with motion. There is no documentation of swelling of the joint and no radiographic findings suggestive of osteoarthritis. There is a current recommendation from the orthopedic surgeon that the patient undergo arthrodesis, interphalangeal joint, with or without internal fixation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient has persistent pain which he reports arising in the DIP joint. There is no documentation of osteoarthritic changes on plain x-rays of the joint, no effusion of the joint and no documented diminished range of motion. Fusion of the DIP joint would be indicated if severe osteoarthritis was evident and 6 months of conservative treatment was provided. Neither circumstance has been documented. The medical record lacks the documentation of clinical circumstances which would substantiate the necessity of DIP fusion of the right ring finger.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**